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HOMEOPATHIC APPROACH TO PRIMARY DYSMENORRHEA MANAGEMENT: A CASE REPORT

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ABSTRACT

Primary dysmenorrhea (PD) is a common condition among females, significantly impacting their quality of life and academic performance due to frequent absences. These absences, often caused by experiences like menstrual pain, can have adverse effects on students' educational achievements. Dysmenorrhea, characterized by painful menstruation, is a frequent complaint among women seeking medical help. It manifests as either sharp or dull pelvic or lower abdominal pain. Primary dysmenorrhea (PD) specifically affects healthy women without pelvic organ abnormalities, predominantly occurring in adolescent girls. In contrast, secondary dysmenorrhea arises from pelvic pathology and may require surgical intervention. Treatment for PD often involves the use of homeopathic medicines, including constitutional anti-miasmatic and specific remedies, which have shown considerable efficacy. **Case summary**: This was a case of a primary dysmenorrhea in a patient aged 20-year presented to Homoeopathic hospital at outpatient department received individualized homoeopathic remedy. She had intense periodic pain in lower part of abdomen during menses over the last 5 years. And she used to take pain killers for relief. Homoeopathic treatment was started with *Liium Tigrinum* and later on *Sepia* on the basis of totality of symptoms and reportorial analysis. Which showed reduction in pain much more than before and overall improvement was seen in patient. Intensity of pain was measured by using a visual analogue scale (VAS). This evidence-based case which was reported in accordance with HOM CASE guidelines indicated that individualized homoeopathic remedies can be safely used to treat condition like primary dysmenorrhoea.

INTRODUCTION

Primary dysmenorrhoea is a common condition characterized by painful menstruation in absence of any kind of pelvic pathological condition and many times it is accompanied with additional symptoms such as diarrhoea, vomiting, back pain, headache, tiredness, and dizziness. Approximately half of all young women have experienced primary dysmenorrhoea often present from the beginning of menstruation and throughout life, which typically requires a thorough and carefully taken patient's history for a proper diagnosis [13] The ICD—10 code for primary dysmenorrhoea is N94.4.[1] and The prevalence of PD in women of reproductive age varies between 45-95 % globally, with around 2-29 % experiencing severe pain. [5,17]. Moreover, according to a specific study, conducted on young Indian college girl students showed a prevalence of dysmenorrhoea exceeding 45%.[22]. Although a previous Indian study included students aged between 18 to 29 years old, the incidence of dysmenorrhea is most commonly reported among women aged 20 to 24. [26]. Dysmenorrhoea can be classified into two categories - primary dysmenorrhea (PD) and secondary dysmenorrhea (SD). PD is characterized by menstrual pain without any underlying pelvic disease or any kind of structural abnormalities. Generally, it starts within the first two years after menstruation begins (menarche), once regular ovulation has commenced [18,6].

The onset of primary dysmenorrhea generally occurs at menarche, or within the subsequent 6 to 12 months, upon establishment of ovulatory cycles. This pain commonly persists for two to three days, occurring concurrently with or shortly before menstruation [8]. Unlike primary dysmenorrhea, which occurs without any underlying pelvic issues, the secondary dysmenorrhea is

characterized by menstrual pain resulting from underlying pelvic abnormalities, including chronic pelvic inflammatory disease, endometriosis, endometrial polyps, adenomyosis, and complications related to intrauterine devices [5,18]. Despite ongoing debate surrounding its exact cause, it is currently thought to be caused by excessive or imbalanced prostanoid (including prostaglandin) release from the endometrium during menstruation. These substances lead to frequent and irregular uterine contractions, decreased local blood flow, and heightened sensitivity of surrounding nerves [12,11]. Elevated levels of vasopressin, a hormone that promotes muscle contraction, is another contributing factor [24]. Although not life-threatening, primary dysmenorrhea is a key health concern that healthcare professionals must address, as it impacts women's quality of life negatively [7]. The fact that only 14.2% of females consult healthcare professionals regarding menstrual cramps, suggests the importance of implementing screening programs for all adolescent girls [20]. This condition has a substantial negative impact on quality of life, results in considerable diminished work productivity and significantly affects school attendance. [14,16]. Two common treatment approaches are used: includes nonsteroidal anti-inflammatory drugs (NSAIDs), which inhibit prostaglandin synthesis, and oral contraceptive to prevent ovulation and decrease uterine muscle activity [9,10]. In a 2010 study, Marjoribanks showed that NSAIDs were significantly more effective than placebo for managing pain in primary dysmenorrhoea (OR 4.50, 95% CI 3.85–5.27), however, their use was associated with a higher risk of mild neurological like dizziness, drowsiness, headache and gastrointestinal side effects such as nausea, indigestion. [23]. Although COX-2 specific inhibitors can effectively treat dysmenorrhoea, COX-2 inhibitors have been withdrawn in many countries due to cardiovascular safety issues (Proctor 2006), has contributed to the growing popularity of complementary and alternative medicine (CAM). Complementary and alternative medicine (CAM) has gained popularity among both patients and conventional practitioners, with estimates suggesting that up to 38% of adults use some form of CAM to manage various health issues [4].

Another study - Twenty women participated in a randomized, double-blind, placebo-controlled trial ranging in age from 20 to 48, who received either individualized homeopathic treatment or a placebo. Using a daily symptom questionnaire, the study showed that 90% of the homoeopathy group achieved over 30% improvement, compared to 37.5% in the placebo group ($p = 0.048$) [28]. Even though this clinical trial may benefit from repetition with a larger sample size to enhance its statistical power, it remains promising and supports the observations of numerous medically trained homeopathic practitioners. They consistently find homeopathy to be an effective therapeutic option for PMS, aligning with clinical impressions gained over time. Another study done by Jose DL, Homeopathic constitutional treatment, selected on similarity of symptoms can prevent recurring of painful periods. Mental and physical general symptoms are key to find the most similar remedy. Higher potencies of the selected remedies are believed to be more effective to prevent the future occurrences. According to homeopathic theory of disease, underlying miasms specifically Psora and Pseudopsora, are believed to contribute to play a major role in the development of primary dysmenorrhea. [17]. All the medicines were dispensed from the hospital's pharmacy, which sources medicines from a Good Manufacturing Practice (GMP)-certified firm. The expected outcome was reduction in pain during menses or the disappearance of pain within a plausible time frame after medical intervention. A clinical case report is presented here as per HOM-CASE guidelines. [25]. Assessment of intensity of pain was done by utilizing the visual analogue scale or VAS, This VAS scale shows a simple 0 - to -10 scale by which patient can easily rate their pain intensity, with zero representing 'no pain' and 10 signifying the 'most severe pain imaginable'. [27].

Information of Patient:

A young unmarried girl aged 20, presented with following complaints in the outpatient department on June 5, 2023. She was a student at a physiotherapy college. Her primary complaint was severe lower abdominal pain during menstruation, which had been occurring for the past five years.

Patient had severe lower abdominal pain during menses, bearing down pain was felt especially in uterine region, and the pain was so severe that she feels everything come will come out and she sits with crossed Limbs to feel better, many times she has to press her vulva to feel better. Feeling of fullness in vagina. Bearing down pain in ovaries when standing. The blood flow is dark and offensive. Flow stops when lying down. She is also having complain of brownish leucorrhoea which stains the linen. She was not able to do her routine activity during pain in menses. Not able to concentrate in study due to severe pain. She used to take pain killers for that to get relief but it was a temporary relief.

She becomes very much irritable due to pain. Many times she feels sad and depressed especially during evening time without any reason. She has a fear of being alone too.

No particular physical general character was found. Her appetite was normal, thirst normal, 6-7 glasses / day. No constipation. Sleep for 7-8 hours. No particular dreams. Sweating in general whole body. No specific food craving or aversion. She was equally sensitive to heat and cold.

Menarche started when she was 14 years old. Her menstrual periods were at regular intervals, duration of menses – lasts for 4-5 days. Character of blood flow – dark , offensive and moderate blood flow. Flow stops when she lies down. Severe downward pressing kind of pain in lower part of abdomen during menstruation. especially in uterine region. Better by crossing her legs and pressing the vulva. Bearing down pain in ovaries aggravated in standing posture. Associated complaints – brownish leucorrhoea which stains the cloth.

Clinical Findings : The patient was slender and moderately built, with no abnormalities and no sign of anaemia found during the physical examination. In pelvic examination like inspection of external genital parts there was no any sign of infection in vagina and in bimanual examination of lower abdomen which was done by gynaecologist - the uterus was found to be mobile and no any abnormalities detected.

History of patient : Her complaint of painful menses was present since the beginning of her menses.. She used to take pain killer to get rid of pain. But she was having trouble with pain killers – causes nausea. No other specific complaints in past.

Diagnosis & Assessment : Diagnostic assessment was done according to the detailed Clinical assessment and physical findings of a patient which was essential to rule out any pelvic diseases.

Detailed Clinical assessment like menstrual history of a patient which includes an age of 1st menstruation, how regular her periods are, and how long it lasts, quantity of bleeding , onset of dysmenorrhea, characteristic of pain in which kind of pain, where it is located, does it spread to the other parts, any accompanying symptoms and their timeline, what kind of treatment used so far in the past for same complaint, if any family history of painful menses and also sexual history of patient everything was taken into consideration. She had no history of any systemic disease and it suggested the typical pain of primary dysmenorrhoea, but still Systemic examination was carried out which showed no history of any disease.

Therapeutic Intervention: The case was thoroughly taken and the patient was prescribed individualized medicine after repertorisation and repertorisation was done by a Kent repertory of HOMPATH software. [21]. The ultimate selection of the medicine and prescription for the case management was built upon the totality of symptoms of the patients and also the repertorial results [Figure 1]. In this case, medicine was given in globules and 4 to 6 globules of size number 30 were being given orally on an empty stomach. The 30C potency of *Lilium Tigrinum* was given twice in day for 07 days through miasmatic analysis and then in follow ups according to the condition of patient, the potency needed to be increased and the 200C potency of the same medicine was given. During the follow-ups, when the patient was improving, according to the condition of a patient the new totality of the symptoms was formed and after repertorisation the single dose of *Sepia* 200C potency per month was given [Table 1]. VAS score was 8 on scale. LMP was on 22nd May. As per the reportorial result, the 1st prescription was done on 5th June 2023, *Lilium Tigrinum* 30c was administered. Twice daily for one week

and then placebo was given for 21 days. Patient was asked to report after one month after her next menstrual cycle

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Date	Complaints	Prescribed Medicine
5th June 2023 1st prescription	• LMP was on 22nd May • Severe lower abdominal pain during menses, Bearing down pain was felt especially in uterine region, • The pain was so severe that she feels everything will come out and she sits with crossed limbs to feel better, many times she has to press her vulva to feel better. • Very much Irritable due to pain. • Feeling of fullness in vagina. Bearing down pain in ovaries when standing. • The blood flow is dark and offensive. • Flow stops when lying down. • She is also having complain of brownish leucorrhoea which stains the linen. • Feeling depressed and sad especially during evening period with fear of being alone. • *VAS score was 8 on scale.	*Lilium Tigrinum 30c*/Twice a day(BD)/ 1 Week Placebo / twice a day/ 3 week
1st July 2023 1st follow up	• LMP was on 18th June • She felt little bit reduction in pain during menses, but not much. • Leucorrhoea was present , • Bearing down in ovaries was reduced very much after taking medicine. • Fullness in vagina still present. • No new complaint was developed. • *VAS score was 7 on scale.	*Lil Tig 30c*/Twice a day(BD)/ 1 Week Placebo / twice a day/ 3 week
25th July 2023 2nd follow up	• LMP was on 13th July • She reported same things which she narrated in 1st follow up. • Pain reduced lit. Bit, but not much, • Fullness in vagina, • Leucorrhoea was still present, • All other previous complaints still present. • * VAS score was 7 on scale.	*Lil tig 200C* / Thrice a day(TD)/ one week Placebo / twice a day/ 3 week
23rd August 2023 3rd follow up	• LMP was on 08th August • Bearing down pain reduced much more, • Fullness in vagina reduced but not much, Leucorrhoea was less in quantity, • She was able to do her routine work during menstrual period which was not possible before. • *VAS score was 3 on scale.	*Lil Tig 200C* / 4 DOSES/ weekly one dose placebo twice a day daily for 30 days.
20th Sept. 2023 4th follow up	• LMP was on 03rd September • She was much better in bearing down pain during menses than before, now she was able to do her daily activity during her periods. • Offensiveness of flow present. • Leucorrhoea reduced but not much. • Fullness in Vagina. • *VAS score was 3 on scale.	*Sepia 200C* /1 DOSE/Monthly placebo – twice a day.
11th October 2023 5th follow up	• LMP was on 30th September • Pain during menses reduced much more and feels better in her all complaints. • She feels better overall – both mentally and physically. • No other new complaints developed. • *VAS score was 2 on scale.	*Sepia 200C* / 1 DOSE/Monthl y placebo – twice a day
6th November 2023 6th follow up	• LMP was on 25th October • Pain during menses reduced much more and feels better in her all complaints. • Leucorrhoea reduced much more, • Able to go to college even during menses. • No other new complaints developed. • *VAS score was 2 on scale.	*Sepia 200C* / 1 DOSE/Monthly placebo – twice a day.

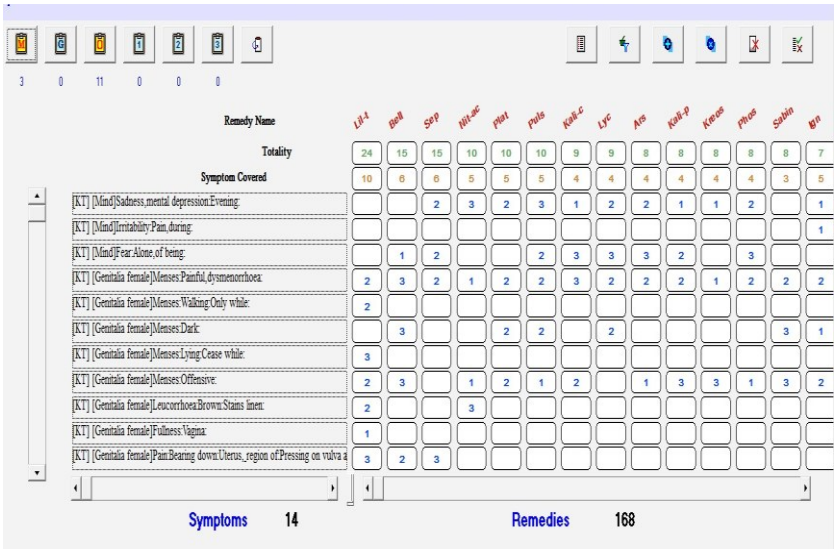

Figure 1 – Repertorisation sheet

DISCUSSION

This case demonstrates several strengths in the management of primary dysmenorrhea (PD) through homeopathic treatment. The individualized approach, on the basis of thorough assessment of the history of patient, specific symptoms & clinical history, led to effective remedy selection. In above case, after meticulous assessment and consultation with Materia Medica, homeopathic remedies were prescribed based on individual symptoms and medical history. In accordance with HOM CASE guidelines , this evidence based case showed the significant improvement after administration of the homoeopathic medicine, which showed that selected medicine was correct, but the improvement was slow when low potencies were given initially, which was *Lil Tig 30C*. However, significant improvement was observed with high potencies of *Lil Tig 200C*. Also there was a remarkable improvement particularly in her main complaint of bearing-down pain in lower abdomen during menses.

Considering the remaining associated complaints, the patient was prescribed 1 dose of Sepia 200C as intercurrent remedy. Lil Tig is a anti-psoric and pseudo-psoric remedy while sepia is a sycopsoric remedy.[3]. Patient was improved a lot within just one month and she was feeling much better overall both physically and mentally. General health of patient was improved with single, individualized constitutional homeopathic medicine.

This case has shown the value of holistic approach which means treating the patient as a whole and considers the patient as an individual rather than just considering their disease symptoms only

The literature on dysmenorrhea consistently emphasizes the prevalence of PD and the significant impact it has on women's lives. NSAIDs remain the first-line treatment, but their side effects—such as gastrointestinal issues and drowsiness—can deter compliance and affect overall quality of life [19]. A growing body of research highlights the potential of homeopathy as a complementary approach, showing promising results in alleviating dysmenorrhea symptoms without the adverse effects associated with conventional medications. Homeopathy's focus on the totality of symptoms aligns well with contemporary holistic health approaches, which advocate for the integration of mental and emotional well-being in physical health treatment.

The positive outcomes observed in our case, where individualized homeopathic treatment led to a significant improvement in the patient's primary dysmenorrhea, are supported by the findings of a robust double-blind, randomized, placebo-controlled clinical trial by Ghosh S et al. Their study, involving 128 patients, demonstrated that individualized homeopathic medicines were significantly more effective than placebo in reducing pain intensity and improving overall symptoms over a 3-month period. This aligns strongly with the principles of individualized prescribing that guided the successful remedy selection in our case.[15] Further supporting the potential of this approach is the single-blind, randomized, placebo-controlled trial conducted by Singh P also found a statistically significant reduction in pain (VAS scores) in the homeopathy group compared to placebo following individualized treatment based on the totality of symptoms. The frequently prescribed remedies in their study, such as *Colocynth* and *Pulsatilla nigricans*, demonstrate the diverse range of homeopathic medicines that can be effective.[23]

However, it is important to consider the findings of a double-blind, placebo-controlled randomized trial which found no significant difference in pain intensity or quality of life between homeopathy and placebo. This discrepancy may highlight the crucial role of meticulous individualization in homeopathic treatment. While their study did observe some improvement within the homeopathy group compared to baseline, the lack of significant difference against placebo suggests that the specific approach to remedy selection and the level of individualization may be critical factors in the effectiveness of homeopathy for primary dysmenorrhea.[2] The contrasting results of their study underscore the need for further research to clarify the optimal application of homeopathic principles in this context and to identify the key factors that contribute to positive outcomes. The consistent emphasis on individualized treatment in the positive studies highlights its potential importance in achieving therapeutic success.

The conclusions drawn from this case report are supported by the observed improvement in the patient's symptoms and quality of life following the homeopathic treatment regimen. Furthermore, the lack of adverse effects associated with the prescribed homeopathic remedies reinforces the rationale for considering this treatment modality as a viable alternative or adjunct to conventional therapies. The case study indicate not only an initial response to treatment but also a broader enhancement in the patient's overall well-being.

The importance of a personalized approach in homeopathy is crucial for effectively managing dysmenorrhea. Patient's specific symptoms and constitutional factors can lead to better outcomes. Integrating physical and emotional symptoms in treatment decisions is vital. Homeopathy's focus on the whole person aligns with modern holistic health principles, addressing not just the physical manifestations of PD but also the psychological impact. However, larger-scale studies with controlled methodologies are necessary to validate these findings. This could help establish homeopathy as a more widely accepted treatment option and reduce reliance on conventional medications with side effects. The positive outcomes in this case underscore the role of homeopathy in enhancing women's quality of life, empowering them to seek alternatives to traditional treatments.

In conclusion, this case report serves as a testament to the potential of homeopathy in managing primary dysmenorrhea, advocating for a shift towards more personalized and holistic treatment approaches in gynaecological care.

CONCLUSION

The individualised homoeopathic medicine *Lilium Tigrinum* and *Sepia* were found to be beneficial in this case with improvement in impact on daily living during menses. This case suggests that homoeopathic medicines when given to the patient on the basis of individualisation can be useful in primary dysmenorrhoea where a long-term dependency on conventional treatment is usually required. Homeopathy offers a diverse range of medicines tailored to each individual, potentially enhancing women's quality of life by addressing conditions like PD. It's vital to stress the importance of educating patients about PD as a treatable condition. It's essential to empower women to explore alternative solutions that may have been overlooked. However, further research is necessary, employing validated outcome measures, proper blinding, and appropriate comparator groups. Larger sample sizes and longer study durations are needed to assess long-term outcomes effectively.

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